80 recommendations the final report is committee the the povernor of unification on unification on public the public mental health system



WILLIAM G. MILLIKEN, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING LANSING. MICHIGAN 48926 FRANK M. OCHBERG. M.D. Director

January 30, 1980

Honorable William G. Milliken Governor of Michigan State Capitol Lansing, Michigan

Dear Governor Milliken:

I am pleased to transmit to you the final report of your Committee on Unification of the Public Mental Health System.

The eighty recommendations in the report propose a comprehensive approach to assuring an equitable distribution of basic mental health services throughout Michigan.

The Committee members and I look forward to presenting the report to you personally. The Committee has formally asked me to convey to you its willingness to work with you and the Legislature in implementing the recommendations you adopt. Their investment in, and support of, these recommendations is great and their knowledge of our program goals will be a strong asset as we move toward a single, unified mental health system.

Sincerely,

Valtehman, M. D.

V. A. Stehman, M.D.

cc: Frank M. Ochberg, M.D.

The Governor's Committee on Unification of the Public Mental Health System

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Part I Executive Summary

The Governor's Committee on Unification of the Public Mental Health System recommends establishing a single point of responsibility for voluntary and involuntary entry into Michigan's public mental health system, for determination and oversight of the services it provides, for system exit, and for the resources that support services delivery.

That single point of responsibility is to be located in the community. It is designated as a local mental health authority encompassing one or more counties. Greater responsibilities than are now possessed by community mental health programs are recommended for each authority. Greater authority, including the control of its direct service personnel and fiscal resources, is recommended for the authority.

Each local mental health authority will assure the delivery of public information/education, prevention, client/outpatient, partial day, residential, and inpatient programs to all persons in its service area who are impaired by or at risk of developmental disability, emotional disturbance, or mental illness. Services are to be available, accessible, appropriate, unrestrictive, and provided in accordance with an individualized plan of service. Services are to be directed at defined client impact objectives.

The client services management function that will assure diagnosis, case planning, monitoring of service delivery, and progress assessment is to be available to all clients of the public mental health system. In addition to assuring the direct delivery or contractual provision of services in accordance with these mandates, the local mental health authority may offer supplemental programs to meet unique local needs and it may elect to engage in research and training.

The sharing of system governance recommended by the Committee calls for the Department of Mental Health and the local authorities to jointly: develop standards for services, prepare planning guidelines, set budgetary priorities, engage in personnel resource planning and development, and carry out legislative liaison activities. Reserved to the Department are these functions: communication and negotiation with other state level organizations and with the federal government, the provision of training and technical assistance to local authorities, the consolidation of program and budget planning, monitoring and enforcement of standards for mandatory mental health services, and the provision of those direct services, including research and licensure of private mental health facilities, that are most feasibly administered at the state level.

The principle of shared responsibility is to be extended, via contract, to the operation of state psychiatric hospitals and centers for developmental disabilities, except for those unique facilities that have statewide service areas. Their operation is to remain a Department responsibility.

Recommended program standards include new rules of promptness and due process protections for clients. Development of criteria for entry into and exit from the system and its component programs is recommended. Development of a several step compliance process with clearly stated criteria

for enforcing feasible sanctions is also recommended.

Greater responsibility for total client well-being is recommended for the agencies of Michigan's mental health system. That responsibility begins at the point of initial contact and continues until the responsibility for all client services is accepted by another agency or system. Agencies must also identify the non-mental health services that are essential to each client's attaining his or her mental health objective and actively pursue their delivery. Several recommendations address the mechanisms and administrative supports for the interagency coordination and cooperation that is essential to this comprehensive service delivery.

The Committee recognizes not only the value of local program operation, but also the merit of supporting that local control with local funding. It recommends continued state and local funding for all public mental health services, at the current 90-10 ratio.

In recognition of the difficulties faced by some community programs in getting expansion funds and of the potential impact on local revenues of the Headlee Amendment to the Michigan Constitution, several recommendations are made to support and increase the capacity of county government to provide funds for local mental health services. Finally, the Committee recommends more funding for services to clients of Michigan's public mental health system.

In total, the Committee describes the principles and features of a model mental health system for Michigan in eighty separate recommendations on subjects ranging from the system's purpose and programs, its organizational units and their functions, means of relating to other service delivery systems, to funding.

The complete text of each recommendation and its explanation is presented in Part IV of this report.

Part II The Committee's Charge

Michigan's Constitution declares the care, treatment, and rehabilitation of persons with mental handicaps to be a purpose of government. The state's landmark 1974 Mental Health Code calls for a unified system of statewide mental health care to achieve this purpose. The Code's challenge has yet to be met.

Michigan's mental health services delivery network is fragmented. The separate evolutions of its community, state, and federal components, the disparate distribution of resources, and other factors have resulted in great variations in the availability and extent of the network's services and in their internal and external coordination. Neither people nor information can move among system units as required for sound service delivery and program administration.

Current and potential system users are frustrated by the limitations of existing services and by the lack of even properly disseminated information about services. Those who provide resources are frustrated by the system's lack of accountability and responsiveness. Service providers are frustrated by the frequently fruitless dissipation of their time and energies. More globally, no coordinated and proactive approach has been taken to implement what are now the hardly new legal and treatment philosophies of delivering comprehensive mental health services in more normal and less disruptive community settings.

The human, organizational, and fiscal size of Michigan's mental health service delivery system, as well as the limits posed by available technologies and resources, make change a complex problem. It is not, however, an insurmountable one. Actors at all levels of the system have taken and continue to take steps to improve and integrate services.

When these issues and change efforts were brought to the attention of Governor Milliken he acted to assure a more comprehensive and organized approach to change. In his January 1979 State of the State Message he announced:

The mission of the mental health system is to restore, improve and/or maintain the functional ability of individuals who experience severe dysfunction or disability as the result of a developmental disorder or form of mental illness.

"The Michigan Mental Health Code provides for the delivery of this service through two separately administered systems at the state and county level, but requires that the Department of Mental Health coordinate and integrate these two systems. Separately administered systems do not produce a well-managed and accessible system. Therefore, I have adopted development of a unified public mental health system as a priority. I have directed the state to assume an aggressive role to assure an equitable distribution of basic mental health services.

"The public mental health system is to reflect the following principles and features:

- State services shall include inpatient, alternative residential, partial day, outpatient, and public information/education services.
- Within available resources, fiscal support by the state will require mandatory programs for registered cases of developmental disabilities and mental illness.

- The state shall be responsible for developing program standards including definitions of mandatory services, admission and case management criteria, monitoring, a program and fiscal audit capacity, and an administrative hearing procedure.
- It is anticipated that most counties or groups of counties will administer all or part of the mandatory services. They shall assume full responsibility for operation of the mandatory services when willingness and capacity is demonstrated. Counties or groups of counties may choose to have the state assume responsibility for administering some or all mandatory state services within their geographical boundaries. Counties may also use local funds to enrich or supplement mandated services and will participate in local needs assessment.

"I am appointing a committee to advise me on implementation of this program and to examine issues, develop legislative proposals, and suggest administrative alternatives. It will be chaired by the acting director of the Department of Mental Health and the membership will reflect the concerns and interests of the general public. With technical assistance provided by the department, the committee will report its recommendations to me by September 1.

"I have instructed the department to coordinate policy directives and actions taken in 1979 with the work of the committee, to assure that these principles and features are translated into improved care and treatment. I am expecting these efforts to produce significant visible changes in the delivery of public mental health services within the next two fiscal years."

This report presents the final recommendations of that Committee.

Part III The Committee Process

The members of the Governor's Committee on Unification of the Public Mental Health System were named on March 19, 1979. They are, as intended, a broadly representative group—state, community, and private service providers, labor representatives, consumer advocates, and knowledgeable citizens are among the Committee's twenty-eight members. A complete Committee roster may be found in Part V.

When the Committee was appointed, the Governor requested an interim report by the end of the summer and a final report by December 1, 1979. The interim report was submitted on August 31, 1979. In the report's letter of transmittal the magnitude and complexity of the Committee's charge were noted. Extension of the due date for the final report to February 1, 1980 was requested. This final report is submitted in accordance with the extension granted by the Governor when he met with the Committee in September.

The full Committee has held ten day-long meetings at regular intervals between April 10, 1979 and January 15, 1980. Its four Subcommittees, on system mission, on definitions and standards for services, on administration and finance, and on systems relationships, have held forty meetings to research and deliberate recommendations for full Committee action. The Committee additionally held nine public hearings throughout Michigan and reviewed numerous letters and reports to learn the concerns and suggestions of interested persons.

The Committee's members are to be commended for their tremendous investments of time in this project. More significantly, they are to be commended for their thorough, open, and honest exploration of all the many issues involved in

developing the principles and general features of a model public mental health system. Most significantly, they are to be commended for making the client the focus and starting point of their work and for recognizing the totality and extent of the client's need for services.

In accordance with the Governor's directive, the Department of Mental Health has been regularly coordinating its work with that of the Committee. The Committee's staff is housed in the Department's Office of Services Unification and draws upon the technical assistance provided by personnel throughout the Department. Department and Committee staff have been in regular contact with members and staff of the Michigan Legislature to learn their concerns for, and keep them abreast of, the Committee's work.

A complete review is now underway of all of the Committee's recommendations to determine the short term and long range actions needed to implement them. The Department will formally respond to the Committee's report. Following the Governor's review of and response to the Committee's report and the Department's analysis, the implementation action he directs will be taken.

The Committee looks forward to seeing the impact of its work in changes in statute, in policy, and in the deployment of resources throughout Michigan's public mental health system.

Vastehman, M.D.

V. A. Stehman, M.D. Committee Chairperson Chief Deputy Director Michigan Department of Mental Health

Part IV Recommendations



The Public Mental Health System RECOMMENDATION 1

It is the mission of Michigan's publicly funded mental health system to restore, improve and/or maintain the functional abilities of persons who are developmentally disabled, emotionally disturbed, or mentally ill by providing or assuring the provision of direct services, including primary prevention services to reduce the incidence of these conditions, and to support and encourage research and training activities.

The persons requiring services from the public mental health system include not only those who are developmentally disabled, emotionally disturbed, or mentally ill, but also those who are at risk of these impairments, those who require primary prevention services, and those who are multiply impaired.

The public mental health system will provide a comprehensive range of direct and indirect services appropriate to individual characteristics and need.

EXPLANATION

A unified public mental health system should have a single statement of its ultimate aim, of the condition it is directed at attaining. After studying several existing and proposed mission statements as well as the characteristics of mission statements generally, the Committee recommends the above mission statement for Michigan's public mental health system.

The Committee intends it to be a broad and non-exclusionary statement of purpose. The Committee notes that while there is as yet no generally accepted definition of "emotionally disturbed." both mental health professionals and the general public distinguish between that term and "mental illness." The Committee believes that the mental health system's responsibility for emotionally disturbed persons should be noted.

Client Services

RECOMMENDATION 2

The overall objective for serving a client in a mental health program shall be that of prevention, psycho-social adjustment, crisis resolution, rehabilitation/habilitation, or maintenance. The definitions for each of these client impact objectives are:

Prevention—To minimize the likelihood that a person becomes a client of the mental health system through reduction of the incidence of emotional, behavioral, or mental dysfunction and of developmental disability.

Psycho-Social Adjustment—Improvement in functional abilities of a person experiencing specific stressful situations that interfere with the maintenance of family, school, work, interpersonal, and community relationships. The degree of dysfunction of a client needing psycho-social adjustment

services is mild enough so that his/her level of functioning can be improved by providing services on a systematic. periodic basis.

Crisis Resolution—Reduction or removal of acute mental, emotional, or behavioral stress and its physical and social manifestations in order to ensure the safety of the individual and society.

Rehabilitation/Habilitation—The development and/or reacquisition of basic or advanced daily living skills and/or work related skills that will increase the client's capacity for maximum functioning.

Maintenance—Retention and application of acquired skills and behaviors. A client assigned this objective through the individualized plan of service process needs active, supportive programming which may be of either short range or long term duration.

EXPLANATION

Client impact objectives describe the general purpose for placing a client in a particular program. Their use fosters appropriate program placement and encourages continued, consistent delivery of services toward a client-centered purpose. The client impact objectives recommended by the Committee are derived from those already in use in Michigan's mental health system.

Programs and Activities

Mandatory Mental Health Programs RECOMMENDATION 3

The Mental Health Code and its Administrative Rules should be changed to require local mental health authorities to provide for the availability of the following mandatory programs:

Public Information/Education Services—Educational and informational activities designed to increase knowledge and understanding of client needs and characteristics and of mental health services and delivery systems. Such programs include adequate publicity on the criteria for receiving mental health services and on the types of services available to citizens of Michigan. Public information/education services will be directed to potential user audiences such as parents of preschool children, children and youth, the elderly, and other human service agency personnel, as well as to the general public. All system intake procedures and personnel must be responsive to all forms of requests for services and answer them in language that is readily comprehensible to the inquirers.

Prevention Services—Services to persons at risk of becoming clients of the mental health system that reduce the incidence of emotional, behavioral, and mental dysfunction and of developmental disabilities (e.g. genetic counseling, prenatal health education).

Client/Outpatient Services—Services provided to clients whose degree of need, as determined through the individualized plan of service process, is mild enough that intermittent, non/residential services are required to develop or strengthen a level of skill that enables them to function independently within the home, family, and community.

Partial Day Services—Planned and systematic sequences of training and therapy tailored to client need, as determined through the individualized plan of service process, delivered in a setting other than residential or inpatient and with a frequency and duration that will improve the clients' functioning in the community.

Residential Services—Twenty-four hour per day settings which provide training and/or therapy services in addition to 24-hour support/supervision. The behavioral impairment levels of persons admitted to these settings are severe enough to warrant the availability of services 24 hours per day.

Inpatient Services—Treatment and/or training provided on a 24-hour per day basis in hospitals or nursing care facilities due to the degree and intensity of the patients' medical and/or psychiatric needs. as determined through the individualized plan of service process.

EXPLANATION

The Mental Health Code now empowers the Department to provide any kind of client service including, but not limited to prevention, diagnosis, treatment, care, education, training, and rehabilitation. Community programs may provide prevention, consultation, collaboration, educational, or

information service; diagnostic service; emergency service; inpatient service: outpatient service: partial hospitalization service; residential, sheltered, or protective care service; habilitation or rehabilitation service; and any other service approved by the Department. However, a twenty-four hour emergency intervention service is the only program that the Administrative Rules for the Code actually require community programs to provide.

The Governor proposed that these basic services be equitably available throughout the state: inpatient services, alternative residential services, partial day services, outpatient services, and public informationseducation services. The Committee has provided definitions for these services and has added prevention services to the array of basic services which must be available throughout Michigan to assure equal and adequate treatment opportunity for all clients of the public mental health system. The Committee is recommending prevention as both an impact objective and a program to reiterate the mental health system's responsibility to serve at-risk populations.

Support Services

RECOMMENDATION 4

Support services are those services which the interdisciplinary team specifies as being required in addition to basic mental health programming for the client to attain his or her mental health objective. Support services may include, but are not limited to: speech and language therapy: audiology: physical and occupational therapy: transportation: recreation: medical and dental services: special education: education: parent training: developmental and corrective equipment: housing: food: janitorial, artistic, and cultural programs: religious services: legal services: and vocational training.

EXPLANATION .

Mental illness, emotional disturbance, and developmental disability can have multiple impacts on life skills and functioning. The likelihood of multiple impacts generally increases as the severity of the impairment increases. If mental health services are delivered without attention to the total person, they may be ineffective.

This recommendation requires the mental health system to define as support services those non-mental health services which are integral to successful outcomes for mental health service delivery.

The Committee notes that, in general, the number of support services will increase in direct relationship to the severity of the client's impairment, the intensity of treatment, and the restrictiveness of the service environment. A mildly impaired person, such as a client with a psycho-social adjustment objective served in a client/outpatient program, is likely to require few or no support services. A client with a rehabilitation/habilitation objective served in an inpatient program will probably require many support services.

Substance Abuse Services

RECOMMENDATION 5

The office of substance abuse services should be moved from the Department of Public Health to the Department of Mental Health.

EXPLANATION

Substance abuse problems are symptomatic of dysfunctional behaviors and often result from mental health problems. A public health treatment model is not adequate to successfully rehabilitate the total person.

Many substance abuse agencies have in fact been functioning as mental health outpatient/inpatient facilities. Apparently, however, increased pressure is being placed on them not to address the mental health needs of their clients. Mental health programs are instead being asked to provide services such as diagnostic work-ups, psychiatric services, and other therapies. This causes numerous administrative problems which dilute adequate services to clients.

Integrating substance abuse programs with mental health programs will lead to more efficient and effective service delivery to clients.

Supplemental Programs

RECOMMENDATION 6

Supplemental programs are defined as programs, services, and activities which a local mental health authority elects to arrange for or to provide, and which are directed at achieving mental health objectives.

EXPLANATION

As indicated by the Governor in his charge to the Committee, in addition to supporting the uniform availability of basic services, an adequate public mental health system should provide for unique local needs and priorities. The Committee has formulated a definition for such supplemental programs.

Research

RECOMMENDATION 7

The research that is to be supported by Michigan's public mental health system is defined as: the systematic application of disciplined scientific inquiry and hypothesis testing that is structured toward answering questions about causes, prevention, and treatment of mental dysfunction and methods of administering mental health programs.

EXPLANATION

As indicated by its mission statement, the Committee considers that research is essential to improving the efficacy of mental health services. It supports continuing research as a responsibility of Michigan's public mental health system. The recommendation proposes a definition for research which tollows one prepared by the Technical Advisory Research Committee of the Department of Mental Health.

Training

RECOMMENDATION 8

The training activities that will be supported and encouraged by the public mental health system include:

- A. Initial and ongoing training of its direct service and management personnel:
- B. Internship, residency, and other practicum opportunities for persons preparing to enter mental health and related professions; and
- C. Education and training for generic service providers and other community care givers.

EXPLANATION

Training of persons who work with or have regular contact with clients of the public mental health system, so that these persons attain skills needed to effectively help potential, present, and past clients, is basic to the delivery of adequate and appropriate mental health services.

Service Delivery Principles

RECOMMENDATION 9

Appropriate amendments shall be made to the Mental Health Code and/or its Administrative Rules to ensure that all services delivered by public mental health agencies are done so in accordance with the following service delivery principles.

Accessible—Mental health programs shall be arranged so that clients who are in need of these services can easily obtain them. Distances, transportation arrangements, hours of operation, and physical facilities shall be designed to facilitate the receipt of service by mental health system clients.

Appropriate—The services provided are those suited to the assessed needs of the client and specified in an individualized plan of service designed by an interdisciplinary team to enhance client strengths and to reduce areas of dysfunction.

Available—Services which either are presently in place or must be developed to meet client mental health needs. The services must also be accessible to meet availability criteria. Mental health services will be provided without delay to persons under involuntary order of the probate court to receive those services.

Least Restrictive Alternative—Services, as well as settings in which they are provided, are appropriate to evaluated client needs and do not interfere with individual freedom or with human dignity.

EXPLANATION

Although these service delivery principles are widely accepted as necessary to the appropriate provision of mental health services, the Mental Health Code and its Rules do not require that all agencies of the public mental health system adhere to them.

Coordinated Service Delivery

Focus

RECOMMENDATION 10

For maximum benefit to the client, services coordination must function effectively at the client level.

EXPLANATION

If mental health clients are to achieve their service objectives, then, as indicated by the recommendation on support services, they must receive many different services. Some of these services are not being, and should not be, provided by mental health system agencies. Involving multiple agencies in service delivery requires attending to their coordination, most critically at the focus of service delivery, the client.

Agency Responsibility

RECOMMENDATION 11

Agency responsibility for assuring that the client's basic service needs are met begins at the initial contact by any client. The agency shall be responsible for the client until responsibility is redirected by the development or revision of the individualized plan of service. The agency is not released from responsibility to the client until it is confirmed that responsibility for all services to the client has been accepted by a subsequent agency.

EXPLANATION

The complexity of Michigan's several human service delivery systems makes it easy for persons in need of services, and especially the most vulnerable of them, to be shuffled from agency to agency, to 'fall through the cracks' and to be without services. During the sometimes lengthy diagnostic and planning process and as a client moves between delivery systems, the client continues to need basic services.

The Committee knows that the superagency approach to this problem is neither feasible nor desirable. It also knows that ultimately, no agency can be held accountable for the delivery of services that it neither delivers nor purchases. Nevertheless, the Committee recommends that mental health system agencies assume responsibility for basic client well-being from the point of initial client contact until the client either no longer needs services, refuses services, or formally becomes the responsibility of another agency or service system.

Responsibility for Support Services RECOMMENDATION 12

While it is recognized that support services as defined may not be the primary responsibility of the public mental health system, the active pursuit of the provision of those support services that are essential to attaining the client's mental health objective shall be a mandatory responsibility of the mental health system.

EXPLANATION

The actual delivery of, and/or payment for, support services may be the responsibility of other agencies, as directed by federal and state law and agency policy. The public mental health system is hardly unique among human service systems in sometimes failing to meet its responsibilities in a timely and adequate way. Yet, the failures of other systems can slow or stop the successful delivery of mental health services.

This recommendation requires agencies of the public mental health system to assume some responsibility for the delivery of support services. In some instances this may simply require being knowledgeable of who is providing what services and involving those providers in the program planning process to promote harmony of effort. In other instances the mental health agency may have to actively pursue, through advocacy or with services coordination strategies, the timely and appropriate delivery of support services. Finally, as the definition of support services implies, in instances where no other agencies are charged with providing or paying for identified support services, the public mental health system must assume the cost of providing them.

The Client Services Management Function

RECOMMENDATION 13

The client services management function shall be a mandatory function available to all public mental health system clients.

The client services management function is defined as single responsibility for assuring these administrative, facilitative, and advocacy functions: that appropriate client assessments are performed; that an individualized plan of service is developed and implemented; and that planning, coordination, facilitation, monitoring, recordkeeping, and advocacy activities are taking place on behalf of the client.

EXPLANATION

The Mental Health Code, its Rules, various funding and accreditation agencies, and Committee recommendations all require the timely and documented performance of mental health assessment, of program planning, of service delivery, and of progress oversight. The Committee is recommending that agencies of the public mental health system assume responsibility for assuring that each client's basic needs are met from the point of initial contact until the client exits the mental health system, refuses services, or formally becomes the client of another system. The Committee is also recommending that those basic service needs include identified support services which may be neither provided nor purchased by the mental health agency.

The client services management function is recommended as the means by which mental health system agencies julfill their responsibilities for comprehensive and coordinated service delivery. It will pose a single point of accountability for client services.

Program Planning Process

RECOMMENDATION 14

The services to be provided to each client of the public mental health system shall be determined through the following process.

- A. Each client of the mental health system will be assessed in at least areas of psychological, medical, social, and vocational/educational functioning.
- B. Diagnostic assessments of educational, sensory/motor, self/help, psychiatric, speech/language, living arrangements, and other areas of client functioning will be assessed based upon the suspected degree and type of handicapping condition of the client.
- C. Once all relevant assessments are completed by a person(s) qualified to administer and interpret such assessments, an interdisciplinary team will be convened to use assessment data in developing an individualized plan of service and to re-examine client needs at least annually or more often, based on client progress and as required for clients in state facilities, as stated in the Administrative Rules for the Mental Health Code (see Part 4, subpart 4, and Part 5, subpart 4 in Rule 330.7199 (0)).
- D. The membership of the interdisciplinary team shall include: the client and/or the client's guardian or representative, appropriate representatives of all areas of mental health services being provided for the client, and other representatives of non/mental health agencies offering services that are integral to achieving the client's mental health goal(s).

EXPLANATION

The assessment procedures stipulated in the Mental Health Code are now guaranteed only to persons in inpatient facilities. Persons in need of other mental health services may have neither assurance of nor access to assessments—that would help determine their specific needs.

Individualized assessment and planning are the basis for appropriate and effective service delivery. The essential purpose for collecting diagnostic data is the development of a mental health program that enhances client strengths and reduces client weaknesses.

The more extensive a client's handicapping condition, the more services will be required to accomplish this purpose. For example, the composition of an interdisciplinary team for a client experiencing mild emotional difficulties might be only two persons, the client and the therapist. Team composition for a client with more extensive service needs would be larger and more varied.

Components of the Individualized Plan RECOMMENDATION 15

The individualized plan of service shall minimally include the following content:

- A. Section I—Demographic and reporting data
- B. Section II—Types and dates of evaluations administered, date of interdisciplinary team meeting, and list of participants
- C. Section III—Statement of needs, strengths, and

A statement of the specific problems or disabilities and specific needs as determined through the evaluation process,

including a statement of evaluated strengths and weaknesses in the following areas:

- A description of the degree and type of sensory and/or motor impairment(s), strengths and needs;
- 2. Need for educational and/or vocational development:
- 3. The degree of mental dysfunction and/or client distress:
- The capacity and need for social and recreational programming;
- Medical and dental services required (including special diet, medication review, etc.);
- 6. Drug regimes by type and dosage needed;
- 7. Type of living arrangement needed;
- 8. Physical and/or environmental limits required to preserve health and safety: and
- Other client needs that must be addressed for mental health goals to be achieved.
- D. Section IV—Long and short term objectives, activities to reach them, their duration and frequency, and persons responsible for carrying them out
- E. Section V—Evaluation criteria for each objective to determine the extent of its attainment, the dates for evaluation(s), the person(s) responsible, and results
 - F. Section VI—Signatures

This section contains a statement of participation in the plan's development and agreement with its contents. It is not a binding agreement, but an acknowledgement of participation and initial concurrence. It is to be signed by the client and/or the client's parent, guardian, or designated representative and by an authorized public mental health agency representative.

G. Section VII—The individualized plan of service for every active client shall be reviewed, at minimum, annually.

Additional criteria as set forth in R330.7199 of the Administrative Rules for the Mental Health Code must be fulfilled for persons in state facilities and other inpatient facilities.

EXPLANATION

The individualized plan of service is the single most important tool for providing a client with services appropriate to needs, for monitoring client progress, and for establishing accountability for service delivery. Due to the importance and multiple uses of the individualized plan of service, the Committee recommends criteria for the content of this document. The criteria are derived from current plan content requirements for persons in inpatient facilities and from the previous recommendation on the program planning process.

System Units and Governance

Single Responsibility

RECOMMENDATION 16

Changes should be made in code, rule, policy and practice to establish a mental health system in which access to and use of publicly funded mental health services are arranged through a single source. At minimum this included the provisions for: voluntary and involuntary system entry; determination and oversight of the services to be provided; system exit; and the financial, personnel, and information resources that support service delivery.

EXPLANATION

The Committee has articulated the unified public mental health system proposed by the Governor as a system which provides a single source of access to and responsibility for its services. That source or organizational entity provides entry to the services of its own and other organizations and assures that the services provided are appropriate and sufficient to need. That single source also directs the use of the resources that support service delivery.

Integration of the present dual state and community systems eliminates separate responsibilities for providing services, inefficient duplications in services, and service gaps. A single system of service entry and service assurance does permit multiple, different organizations to be the actual providers of service. It also permits public bodies to either operate services directly or to contract with other private and public organizations for services delivery.

Local Mental Health Authority

RECOMMENDATION 17

There shall be a single local mental health authority responsible for the public mental health needs of all persons in its service area.

EXPLANATION

Consistent with the Governor's call for local program administration, this recommendation places the single source of responsibility for mental health services in the community. It defines that source as a local mental health authority. Local mental health authorities are to have broader responsibilities and more autonomy than do existing community mental health programs. The concept of the local authority is explained further in subsequent recommendations.

The Authority's Purpose

RECOMMENDATION 18

The local mental health authority

- A. Will meet these impact objectives:
 - 1. Prevention.
 - 2. Psycho-social adjustment,
 - 3. Crisis resolution,
 - 4. Rehabilitation/habilitation, and
 - 5. Maintenance:

B. By assuring the availability of these mandatory mental health services:

- 1. Public information/education.
- 2. Client/outpatient services,
- 3. Partial day services,
- 4. Residential services,
- 5. Impatient services.
- 6. Prevention services, and.
- 7. Emergency services: and
- C. By providing for the availability of such supplemental services as it may choose.

EXPLANATION

This recommendation indicates that the local mental health authority is to be the organizational entity that is solely responsible for assuring that clients of the public mental health system attain their objectives and that the mandatory programs through which that will occur are in place. It is also to be responsible for arranging for the appropriate delivery of services that are suited to individually identified need.

Service Area

RECOMMENDATION 19

The service area for the local mental health authority shall be the county. One or more contiguous counties may voluntarily associate to form a single service area. The state shall encourage counties to voluntarily associate. Wayne County shall be viewed as a region and may be further subdivided according to a plan approved by the state.

EXPLANATION

Without speaking to the role of county government in mental health service delivery, this recommendation defines the geographic area to be spanned by the local mental health authority as, at minimum, the county. The county is recommended because Michigan's counties are pre-existing and viable geographical units. There is precedent for and experience with the county as the unit for mental health service delivery.

Closely related services such as public welfare and physical health services also use the county as an organizational unit. That fact does not provide an argument by analogy. But, a mental health parallel should support the development and operation of systems relationships among units which have the same service areas.

In recommending continuing the county as the geographic unit for mental health service delivery, the Committee did consider the alternative of catchment areas, that is, natural population groupings with a minimum and maximum size. Some version of this is recommended for Wayne County, a geographic unit which contains 40 percent of the state's population and which, under the terms of the federal Community Mental Health Centers Act, contains 17 catchment areas.

In sparsely populated areas of the state, catchment areas would, however, require multicounty groupings. Such pooling of resources would expedite service delivery, especially to persons with low incidence impairments. Experience indicates, though, that when state government requires that

uch local associations he formed, the result is hostility, not operation. Therefore, several-county associations are to re encouraged, but not mandated.

Governance Principle

RECOMMENDATION 20

Governance of Michigan's public mental health system vill be shared among the Department of Mental Health and he local mental health authorities. Certain functions will be eserved to the local authorities, others will be reserved to he department, and others will be shared by both.

EXPLANATION

The public mental health system has two basic units. One s the local unit which is, at minimum, responsible for assuring service delivery. The other is a central or state level unit which is, at minimum, responsible for communication and coordination with other state level bodies and the federal covernment. Other functions of the system include: planning and budgeting, monitoring and evaluation, personnel, and inancial management. These functions should be assigned among system units at the point where they are most feasibly carried out. Each unit should have the authority and resources needed to carry out its assigned functions. The Committee recommends the principle of shared governance for determining how those other functions are to be executed in a unified public mental health system.

In making this recommendation the Committee considered and rejected two alternatives, one of state centralized control, and one of total local autonomy.

1. With state centralized control all authority would be vested in the Department's Director. The Department's central office would totally determine how that authority is exercised. The local units would carry out the specific directions of the central office.

This approach would provide uniform services across the state. Its economies of scale would eliminate the problems small, independent units would face in carrying out highly specialized functions. In its extreme form, however, state centralization creates a system that is ultimately unmanageable. It also discourages local initiative and responsibility as well as prompt and flexible response to individual need.

2. With a governance principle of total local autonomy, each local unit would be completely independent in carrying out its functions. A centrally-based unit, if any, would have only duties delegated to it by the local units.

This approach provides for total local authority, responsibility, and initiative. It permits continued inequitable geographic variation in basic services. Total local autonomy doesn't allow local units the information, financial, and personnel resources needed for specialized services and functions.



System Functions

RECOMMENDATION 21

The local mental health authority will execute these functions:

- A. The direct delivery or contractual provision of mandatory mental health services, and
- B. Administrative activities that support the development and operation of mental health services, including:
 - 1. Program and budgetary planning,
 - 2. Program monitoring and evaluation,
 - 3. Personnel and financial management, and
 - Interagency communication and liaison that assure the availability of support services.

It may elect to engage in training and research.

RECOMMENDATION 22

The Department of Mental Health will execute these functions:

- A. Communicate and negotiate with other state level organizations and the federal government:
- B. Provide training and technical assistance to local authorities;
- C. Consolidate mental health program and budget planning:
- D. Monitor and enforce standards for mandatory mental health programs; and
- E. Provide for those services that are most feasibly administered at the state level, including:
 - 1. Research,
 - 2. Dissemination of information about services innovation,
 - 3. Licensure of private mental health facilities, and
 - 4. Specified client services.

RECOMMENDATION 23

Local mental health authorities and the Department of Mental Health will share these functions:

- A. The development of standards for services:
- B. The preparation of planning guidelines:
- C. The specification of budgetary priorities:
- D. Personnel resource planning and development; and
- E. Legislative liaison.

EXPLANATION

With one exception, the functions named in this recommendation do not differ significantly from those which Chapters One and Two of the Mental Health Code now assign to the Department of Mental Health and to community programs. Community programs are there asked to examine and evaluate the public and non-public services necessary to meeting mental health need; local authorities are asked to actively pursue the availability of those services.

The recommended alignment of functions follows from the recommended governance principle. It is also consistent with the Governor's charge to the Committee, of developing recommendations on means of implementing a public mental health system in which program administration is a local responsibility, and funding, standards development, and compliance monitoring are state responsibilities. How most of these functions are to be executed are further detailed in subsequent recommendations.

State Mental Health Facilities

RECOMMENDATION 24

The Department of Mental Health and local mental health authorities will contractually share responsibility for the operation of what are now state mental health facilities, except for these unique facilities: The Center for Forensic Psychiatry, Hawthorn Center, and Lafayette Clinic.

The contract will provide for: services offered, client access, monitoring of progress, determinations of length of stay, and payment for the services provided. The state will provide additional funds to maintain the physical plant. The director of the Department of Mental Health shall facilitate the development of these contracts.

EXPLANATION

State psychiatric hospitals and centers for developmental disabilities provide daily care and treatment for about 10,000 persons. They consume the majority of the state mental health system's attention and resources. The Code, policy, and practice give each of these facilities considerable operational autonomy, for example in allowing each individual facility director to determine who should be admitted to the hospital or center under his or her control.

This recommendation integrates state mental health tacilities into a single system, in a manner consistent with the previous recommendations for single responsibility and shared governance. In making this recommendation the Committee recognizes that control of service access and use is integral to a single system in which responsibility and authority are placed with the local unit. Simultaneously, a contract or other assurance of support is necessary for the tacility to plan its contenued operation.

State tacilities need not be limited to providing only inpatient services; any mandatory or supplemental service which local authorities want to purchase could be provided by the tacilities. The Committee expects the actual provisions of individual contracts to vary with the location of the facility and the interests of the local authority.

Entorceable and enforced entry criteria will be needed to prevent clients from being served in distant and inappropriately restrictive settings rather than in community-based programs. The recommendation additionally recognizes that a small stable state appropriation may be needed to provide funds beyond those furnished by local authorities.

The recommendation exempts from a local authority-sachty contractual relationship those unique facilities which have statewide vervice areas. Writing contracts with as many as 83 local authorities would make the budget processes for these tacilities exceptionally complex. Additionally, knowledgeable local oversight of persons in their are would be difficult to arrange when the facilities are distant from the community.

Although the Hawthorn Center is one of several children's injutical tradition, the recommendation exempls it as a sample tacility. Its enabling legislation was the only mental realth legislation not repealed by the 1974 Mental Health Cale. It is the only comprehensive mental health center for hildren and adolescents that provides outpatient and day irculment programs as well as inpatient programs. It also conducts an active research program.



In developing this recommendation the Committee considered treating state facilities as free-standing entities, able to sell their services as private facilities do now. The state employee status of hospital and center personnel posed problems to this alternative. The point of accountability needed in publicly supported programs was also missing.

Central Program Administration

RECOMMENDATION 25

The Director of the Department of Mental Health shall retain the discretion to organize administrative functions for services to mentally ill and developmentally disabled persons as he/she deems to be most efficient and effective for appropriate and adequate service delivery.

EXPLANATION

Some consumer advocacy groups have proposed that the quality of services to both mentally ill and developmentally disabled persons would be improved through separating their administration. The Michigan Department of Mental Health has, in the past, had separate internal organizational structures for mental illness and mental retardation programs. Its central office is now organized and divided by management functions. Other states, including California and New York, have made this same change, but have now returned to separate organizational structures for mental illness and developmental disabilities.

The Committee considered separating the administration of developmental disability and mental illness services within the Department of Mental Health's central office. Alternatives for moving the administration of programs for persons with developmental disabilities to either the Department of Education or the Department of Public Health were also posed. In making its recommendation, the Committee considered the duplication of management functions and the competition for scarce resources that could occur with separation as well as the duplication and confusion which local authorities would face in dealing with two different state level organizations.



Board Powers and Duties

RECOMMENDATION 26

Each local mental health authority shall have a board of directors that:

- A. Determines policy, plans, and budgets,
- B. Employs staff to execute its functions, and
- C. Receives resources.

The board will be responsible for the operation of the authority's programs.

EXPLANATION

If mental health services are to be delivered in the community, then a local organizational entity must exist to do so. If the services it provides are to be responsive to community needs, then control of the organization should be vested in the community. The vehicle for control should be a body that represents the community in terms of its citizens, leaders, service providers, and service consumers. Assuring the development of the local authority's services and its ability to access the services of other community agencies make it desirable that the authority's governing body be somehow linked to the community power structure.

Simultaneously, the governing body should have enough control over its own resources to be able to exercise its responsibilities. The Director of the Department of Mental Health reiterated this when he asked the Committee to recommend a governing body for local programs that is representative, responsible and accountable.

The Committee recommends continuing a board of directors for the local mental health program. Its recommendation on the purpose of the local mental health authority significantly increases the responsibility of the board. The Committee's recommendation on the alignment of mental health system functions makes the board more accountable by clarifying its relationship with the Department of Mental Health.

This recommendation holds the board more accountable by altering and clarifying the relationship of the mental health board to the county board of commissioners. The commissioners' role will be to appoint mental health board members and to approve the mental health budget. Following that approval, the mental health board will have the autonomy to employ its staff and operate its programs.

Two alternative statements of board powers and duties were considered by the Committee but not recommended.

- 1. The board could be advisory only, giving advice on programs and promoting mental health and mental health programs to the community. The board would have no control over its fiscal and staff resources. It would not be liable for the operation of the local program.
- 2. The board would have limited autonomy in the exercise of its planning, budget, and personnel functions. In planning and budgeting the board's responsibility could vary from

that of only filling in numbers on centrally prepared preprints to that of writing policies, plans, and budgets that are limited only by the provisions of the Mental Health Code. The board's role in personnel matters could vary from only advising on which director should be appointed from a list of candidates prepared by the Department, to hiring a director with qualifications that meet Department-set standards

Selecting Board Members

RECOMMENDATION 27

Mental health authority board members will be appointed by the elected governmental body with jurisdiction over the authority's service area. The appointing authority will be the county board of commissioners.

EXPLANATION

The Committee's Administration and Finance Subcommittee spent a considerable amount of time on this issue without finding a better alternative to the present practice. Committee members agree that commissioner appointment would be useful in increasing the commissioners' sense of responsibility for the mental health program and in gaining local support for it. Those alternatives considered but not recommended are as follows:

1. Board members may be elected, the same way school board members are now elected.

The Committee is concerned that the general public may not be sufficiently interested in and knowledgeable of mental health services for the electoral process to create a representative and responsible body.

- 2. Board members may be appointed by the elected governmental body or bodies with jurisdiction over the authority's service area. The actual appointing authority may be:
 - a. village, township, or municipal governments, with the portion of the board to be appointed by each jurisdiction fixed according to population, or
 - b. the state.
- 3. Board member appointments may be apportioned among several governmental units.

Board Composition

RECOMMENDATION 28

The current provisions for numbers, qualifications, and tenures of mental health board members, as specified in Sections 330.1212 through 330.1224 of the Mental Health Code, shall be continued.

EXPLANATION

Concern was expressed by Committee members and at public hearings for the qualifications of and representation provided by members of community mental health boards. The Committee is aware that in some instances county commissioners may not make sound decisions regarding the expertise that should be possessed by their appointees to mental health boards. Commissioners who appoint themselves to mental health boards may dominate its proceedings and they effectively have the opportunity to vote twice on many of its decisions.

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Boards which contract extensively for services can experience problems recruiting, as required by the Mental Health Code, board members from "agencies and occupations which have a working involvement with mental health agencies." Neither consumer nor professional representation is now required which means their interests can be underrepresented and overlooked. Board members may lack the expertise to effectively communicate with and oversee their professional staff.

Several alternatives were considered at length including:

- 1. reducing the number of county commissioners to be appointed,
- 2. specifying the number of consumers or consumer representatives to be appointed, and
- 3. requiring board member training programs.

No consensus could be reached on how the current provisions for board composition and member qualifications could be effectively improved.



Linking Planning and Budgeting

RECOMMENDATION 29

The planning and budgetary processes for mental health services shall be linked together by:

- A. Requiring the terminology of plans and budgets to be consistent,
- B. Requiring that budgets for program change and creation be consistent with the needs and resources identified in the plan and with the Code, and
- C. Permitting expenditures to deviate from budgets so long as they are consistent with the plan.

EXPLANATION

The failure to link planning and budgeting provides little incentive for good planning. Without good planning, budget change and increase cannot be based on sound data. The Committee makes this recommendation to establish mutually supportive ties between the planning and budgetary functions.

The third element of the recommendation, permitting expenditures to deviate from budgets so long as they are consistent with plans, provides program personnel with the authority and autonomy vital to greater responsibility. It will permit earlier than planned phase-in of new programs if funds unexpectedly become available. It will allow rapid movement of funds budgeted for programs that are underutilized to programs that experience unexpectedly high demand.

The Planning and Budgeting Functions

RECOMMENDATION 30

Each local mental health authority will develop a threeyear plan for its service area. The Department of Mental Health will check the plan only for consistency with the Mental Health Code and the planning guidelines. The local plan will become the basis for the authority's operation. The state plan will be an aggregate of the local plans, as prepared and submitted in accordance with the jointly developed guidelines.

RECOMMENDATION 31

Each local mental health authority will develop a budget that is consistent with its three-year plan.

EXPLANATION

The Committee is recommending that the Department of Mental Health and local mental health authorities jointly develop planning guidelines, that each local authority develop a program and budget plan, and that the Department consolidate local plans and budgets as the state plan and budget. These recommendations further detail how those functions will be carried out.

In making these recommendations the Committee did consider requiring the Department to approve budgets when they are consistent with the local plan and available resources. The Committee also considered and rejected an alternative in which the planning and budgeting process would be directed by jointly prepared, annual Program Policy Guidelines.

Funding Priorities

RECOMMENDATION 32

Persons with known mental health service needs shall be provided with adequate programs before funds are allocated to programs for persons with potential mental health service needs.

EXPLANATION

Setting budgetary priorities is recommended as a joint function of the Department of Mental Health and local mental health authorities. This recommendation provides some direction for that process. Specifically, the Committee supports programs that are directed toward at-risk and community care giver populations. The Committee is concerned, however, that when adequate funds are not available, persons with current mental health needs be served before persons who may or may not have potential mental health needs.



Standards of Promptness

RECOMMENDATION 33

Section 330.1124 of the Mental Health Code shall be revised to:

- A. Prohibit waiting periods of more than ten working days from the date of referral to the completion of diagnostic and assessment procedures;
- B. Prohibit waiting periods for providing mandatory services of more than twenty-five days following the completion of diagnostic and assessment procedures:
- C. Prohibit any waiting period for persons requiring emergency services and for persons under involuntary order of the probate court: and
- D. Require documentation of reasons for exceeding these time frames.

RECOMMENDATION 34

It is recommended that a phase-in period for implementing this Code revision, not exceeding two years, be adopted.

EXPLANATION

The Mental Health Code in Section 330.1124 permits waiting lists for entry into mental health programs. This Section is contrary to the concept of early and prompt intervention. Such early intervention maximizes the opportunity for clients to achieve their mental health goals. It should be noted here that in its principle of availability, the Committee additionally recommends no delay in the provision of services to persons under involuntary order of the probate court to receive them. A subsequent recommendation addresses the compliance and enforcement process and penalties for these and other standards.

Standards for Services

RECOMMENDATION 35

The standards of the Joint Commission on Accreditation of Hospitals (JCAH) and the American Association on Mental Deficiency (AAMD) shall be used as the basis for the standards to be jointly developed by local mental health authorities and the Department of Mental Health.

RECOMMENDATION 36

Within three years of implementing the Committee's recommendations, all public mental health agencies shall be required to comply with JCAH/AAMD standards, the federal regulations for Intermediate Care Facilities for the Mentally Retarded (ICF-MR), and any other jointly promulgated standards.

RECOMMENDATION 37

All local mental health authorities will comply with the Michigan Standards for Community Mental Health Services tracluding updates of these standards) while phasing into compliance with the JCAH/AAMD and ICF/MR standards.

RECOMMENDATION 38

Jointly developed standards shall include criteria for entry into and exit from the mental health system and its component programs.

EXPLANATION

No single, comprehensive, uniformly applied set of standards are used by public mental health agencies to ensure the adequate provision of services. This is a key factor in perpetuating inequity in the delivery of service.

Although the Mental Health Code, its Administrative Rules, Community Mental Health Standards, Program Policy Guidelines, the Staffing Needs Assessment Process, and various Federal regulations all provide some program standards, these documents are not universally interpreted, utilized, or applied. Furthermore, the amount of detail, type of information, and procedures required by current standards and regulations often range from non-existent as in the case of criteria for entry into specific mental health programs, to inappropriate, to overregulation such as in the treatment restrictions for persons awaiting court commitment.

The Committee's Services Subcommittee has reviewed the current Standards for Michigan Community Mental Health Services, the Joint Commission on Accreditation of Hospitals (JCAH) standards, and standards now being developed by Department of Mental Health staff.

The Committee knows that standards development is a time-consuming and rigorous process and that its members lack the technical and clinical expertise to do so. The Committee finds that existing standards have had a positive effect upon the quality of mental health programming. It believes that JCAH/AAMD standards promote excellence in mental health programming, that compliance with them is useful in obtaining resources, and that accreditation brings prestige to agencies.

Due Process Safeguards

RECOMMENDATION 39

Due process safeguards that must be adhered to by all public mental health agencies shall be promulgated and shall contain the following provisions.

- A. Clients (and/or client representatives) shall have the right to seek and present independent assessment information which must be considered by the public mental health agency. This information may be presented as evidence at hearings regarding the client.
- B. Administrative hearings shall be conducted by impartial hearing officers who are not paid employees of the local service providing agency.
- C. Notice shall be given of the right to judicial review when administrative procedures fail to resolve client/agency conflicts.

RECOMMENDATION 40

At the time of system entry all public mental health system clients shall be informed in language that is understandable to them of their service rights and responsibilities and of the procedural safeguards.

RECOMMENDATION 41

The Department of Mental Health shall be responsible for assuring that these recommendations are carried out.

EXPLANATION

Clients (and/or their representatives) of the public mental health system have the right to question decisions regarding assessment, placement, and treatment procedures that effect assignment and/or attainment of mental health goals. Among the features of the public mental health system enumerated by the Governor in his charge to the Committee was an administrative hearing procedure that would protect that right.

The Committee finds that although the Mental Health Code and its Rules contain many references to the rights of mental health service recipients, clearly delineated procedures for assuring the protection of rights are not stated. Individual public mental health agencies must, as set forth in Section 330.1752 of the Code, establish procedures for assuring the protection of client rights.

But, vague language regarding the right to question assessment, placement, and treatment (excluding abuse, neglect, and court commitment procedures), as well as the lack of uniformly applied due process and administrative appeal procedures, causes consumer and professional confusion regarding the responsibilities of public mental health agencies. The recommendation identifies the basic elements of an equitable and single administrative appeals process.

Second Medical Opinions

RECOMMENDATION 42

When mental health system personnel indicate that a surgical procedure should be performed on a client of the mental health system, the client and/or guardian will have the right to request a second, outside opinion at public expense.

EXPLANATION

Providing for the receipt of a second medical opinion will safeguard against misdiagnosis and the performance of unnecessary surgical procedures. Public mental health system decisions regarding surgery affect only the most impaired clients. These clients are dependent upon the public mental health system for most of their health and life support needs. The Committee believes that second medical opinions regarding the need for surgery should be at public expense.

The Monitoring and Evaluation Functions

RECOMMENDATION 43

Each local mental health authority will assure that:

- A. Monitoring information is developed including data on
 - 1. Client well-being and development in relation to their individualized plans of service,
 - 2. The performance of direct services staff,
 - 3. Program performance, cost, and impact, and
 - Consumer and community advice on services and needs;
- B. Evaluation judgments are made in terms of the effectiveness, efficiency, appropriateness, and adequacy of programs and personnel in achieving stated objectives; and

- C. Monitoring and evaluation findings are acted on
 - 1. The revision of plans and budgets,
 - The dissemination of monitoring and evaluation findings via reports that respect individual privacy and provide only aggregated client data, and
 - 3. Other appropriate corrective action.

The Department of Mental Health will:

- A. Provide local authorities with training and technical assistance on monitoring and evaluation,
- B. Review and disseminate both local authority self-reports-and-the-reports of accreditation organizations.
- C. Do on-site monitoring and evaluation of authority programs to assess their compliance with program standards.
 - D. Report evaluation findings, and
 - E. Monitor the development and use of compliance plans.

EXPLANATION

The Committee is recommending that standards for programs and services be jointly developed by the local and state level units of the public mental health system. It is further recommending that monitoring and evaluation of standards compliance and program performance also be functions of both units. This recommendation details how these functions will be carried out.

The Committee considered, but did not select, an alternative approach to monitoring and evaluation in which these activities, as detailed above, would be carried out only by independent organizations with funding and cooperation from state and local mental health system units. With such an approach, the Department and local mental health authorities would be responsible for providing funds and information to the monitors, receiving their evaluation reports, and correcting the deficiencies that are found. The Committee notes that such external evaluation can fit within its recommendation.

Compliance and Enforcement

RECOMMENDATION 44

Non-compliance procedures and sanctions with these minimum features shall be developed:

- A. Clearly stated criteria for employing sanctions against public mental health agencies;
- B. Mechanisms for agencies to appeal non-compliance decisions and sanctions; and
- C. A several step compliance process ranging from voluntary submission and adherence to compliance plans, to state assumption of service delivery responsibilities.

EXPLANATION

The Committee has recommended that the Department of Mental Health monitor and enforce agency compliance with standards for mandatory programs. Yet, there are now only two penalties which the Department can invoke for non-compliance with standards for services: state funds can be withheld or licenselcertification can be revoked. Neither penalty assures that public mental health system clients will receive services after the penalty is invoked. Neither provides for less severe penalties that will result in corrective action to achieve compliance. This recommendation calls for the development of clear and feasible procedures for enforcing compliance with standards.

ersonnel Management

Direct Service Personnel

RECOMMENDATION 45

Each local authority shall have total control over its direct service personnel, including sole determination of:

- A. Their functions,
- B. Their numbers,
- C. Their qualifications,
- D. Their wages and benefits, and
- E. The terms, conditions, and procedural protections governing their employment.

EXPLANATION

This recommendation is consistent with the existing practice of some community programs and would resolve the problems of other programs in which all their personnel. except for the director, are treated as employees of county government. It supports service areas of more than one county. It also supports the authority's accountability by giving it control of a critical resource.

In making this recommendation the Committee considered two alternatives:

1. Fold all mental health employees into the State Civil Service system. A single applicant pool would make it easier for prospective employees and employers to find each other. The time and expertise problems faced by small programs in carrying out personnel functions such as determining competitive salaries, conducting union negotiations, and payroll and bookkeeping would be eliminated.

Local program resource limitations would not constrain paying salaries adequate to attracting and retaining qualisied staff and purchasing costly insurances. The limited transferability of retirement and other benefits that impedes the mobility of personnel among system units would be eliminated as a problem.

The Civil Service system is, however, sometimes cumbersome and slow. It may not be able to provide candidates with unique skills or to provide sufficient incentives to attract persons with in-demand skills to less desirable or isolated communities. It would effectively remove local program employees from the local authority's control.

- 2. Create a separate mental health personnel information service that would
 - a. provide information on competitive wages,
 - h. assist with recruitment,
 - c. negotiate large group purchases of insurances, and
 - d. manage a single pension program.

With such a system each local unit would retain hiring and firing authority. Its flexibility in determining wages and benclits will have to be further defined.

Transferability and Mobility

RECOMMENDATION 46

The Department of Mental Health shall appoint a committee to make recommendations to the director on means of

assuring the mobility of personnel between the State Civil Service system and local mental health authorities. Its membership will include at minimum representatives of: the Department's Central Office, state facilities, local mental health authorities, and employee organizations. The committee shall begin its work by March 1, 1980.

EXPLANATION

The Committee recognizes that its recommendation on direct service personnel does not adequately address the issue of personnel transferability and mobility from the State Civil Service system to the local mental health authority and among local authorities. It notes that a variety of groups have attempted to address these issues (e.g. the Administration and Finance Subcommittee, the Contract Board Steering Committee, and the Department's Central Office). It recommends a renewed and more vigorous effort to deal with the problem.

Volunteers

RECOMMENDATION 47

The public mental health system will develop means and resources for using volunteers to:

- A. Provide services, when appropriate, that cannot be provided by paid staff.
 - B. Act as friends and advocates for clients.
- C. Represent consumer interests in the planning, development, and operation of programs, and
- D. Encourage greater public acceptance of mental health system clients and services.

RECOMMENDATION 48

The Department of Mental Health and local mental health authorities shall develop an appropriate orientation and training program for volunteers and a plan for dealing with volunteers on the issue of confidentiality.

EXPLANATION

Funding is inadequate for mental health system staff to provide some needed client services such as providing social support and one-to-one teaching of community survival skills. At the same time volunteers, including citizens, consumer representatives, and present or former clients, are underutilized by the public mental health system. Research on community acceptance also indicates that the most effective way to change attitudes is through direct personal exposure and interaction. This recommendation provides support and direction for greater use of volunteers in the public mental health system.



Accounting Systems

RECOMMENDATION 49

The Department of Mental Health and local mental health authorities will jointly develop one accounting system for use in all units of the public mental-health-system.

EXPLANATION

Each unit of the public mental health system needs an accounting system through which revenues can be received, bills can be sent and paid, and the status of its budget can be monitored. A single, uniform accounting system used and understood by all system personnel will expedite the flow of information and money among system units. This recommendation supports the local authority's having the responsibility and authority to manage its own budget.

In making this recommendation two other alternatives were considered.

- 1. The Department and the local authorities will jointly identify a range of accounting systems from which each system will pick one to use.
- 2. Each unit of the mental health system will select an accounting system that meets Michigan Department of Treasury standards.

Intercounty Billing

RECOMMENDATION 50

Each local mental health authority shall bill and be reimbursed by the Department of Mental Health for services provided to persons who are not residents of the authority's service area. The Department shall collect the funds paid from the client's county of origin, except for those persons who have no known legal residence.

EXPLANATION

The Mental Health Code does not require counties to arrange for billing and payment for services provided to persons who are not residents of the county in which services are provided. As a consequence, the present voluntary intercounty billing process is not working well. Communities complain of having to use their limited funds for non-residents. The failure of counties of origin to promise and provide funds can block placement of and services to their residents who could be better served in another county. This recommendation requires all counties to bill only one source, the Department, and holds the Department responsible for payments and collections.

Two alternatives were considered but not selected.

- 1. Define residency on a "where found" basis and eliminate the issue entirely.
 - 2. Continue the present practice.

Capital Expenditures

RECOMMENDATION 51

Section 242 of the Mental Health Code shall be amended to permit local mental health authorities to use state funds to construct, purchase, and remodel buildings.

EXPLANATION

State funds for local capital expenditures are now allowed only on an annual rental cost basis. This leaves local programs without a ready source of funds with which to purchase the space needed for program start-up and expansion. This recommendation supports the greater responsibility of the local mental health authority by giving it greater autonomy and flexibility in providing for its physical space needs.

Client Fees

RECOMMENDATION 52

The Committee endorses the principle embodied in Section 824 of the Mental Health Code and recommends that this principle apply to community mental health services as well as to services provided directly by the Department of Mental Health.

RECOMMENDATION 53

Any determination of ability to pay for state and community mental health services shall be equitable for both minors and their parents and for adults.

RECOMMENDATION 54

The Department of Mental Health should appoint a special study committee with consumer representation to review the present methodology for determining ability to pay and to make appropriate recommendations to the head of the Department and to the Governor if legislative change is necessary. This study committee should also review Chapter 8 of the Code as it relates to minors and make appropriate recommendations to protect them from improper divestiture of their own assets.

EXPLANATION

By law, Michigan's public mental health system cannot provide services to all persons without cost, but must charge for services on the basis of their ability to pay.

The Mental Health Code's provisions for the financial liability of individuals, spouses, and parents to pay for mental health services do not apply uniformly to both state and community programs. Additionally, Section 824 of the Mental Health Code stipulates that "no determination of ability to pay that is made by the Department shall impose an undue financial burden on the individual or his family." Nonetheless, the Committee is concerned that the present system for determining the outpatient, day treatment, and inpatient fees that are charged to clients, spouses, and parents may pose an undue burden.

Communication and Liaison

Common Nomenclature

RECOMMENDATION 55

A common nomenclature is needed for the human services activities that are common to multiple agencies. A state interagency task force shall be convened to agree on that nomenclature. The Network Taxonomy shall be the basis for the task force's deliberations.

EXPLANATION

The Committee's recommendations that the public mental health system address the totality of its clients' service needs are challenging. In support of those recommendations the Committee is recommending that interagency communication and liaison be a function of each local mental health authority and that the Department of Mental Health communicate and negotiate with other state agencies and with the federal government. Additional recommendations detail how those functions are to be carried out.

A commonly understood language underlies all services coordination efforts. Yet too frequently, jargon, acronyms, and abstruse professional terminology reduce or stop the flow of communication and services. Different agencies call the same activity by different names. They may also call different activities by the same name. The differential use of the term "day care" in the mental health and public welfare witems is just one example of such linguistic confusion. This babble prompts duplication and gaps in services and redundance in planning. It complicates program monitoring. It trustrates potential users of the service delivery system.

The Committee recommends a state level project to prepare a single catalogue of names for human services activities to be used throughout all of Michigan's human servnes delivery systems. The project's basis should be the Network Taxonomy. That document is the outcome of a similar lengthy and extensive project undertaken by the Muchigan Department of Social Services.

Another real problem is apparent in the language used to identify persons who benefit from mental health system servers. To call them simply "MIs" and "DDs" totally denies their humanity. The terms "persons who are mentally ill" and persons with developmental disabilities" are too long and clumsy for the rapid or repeated use in lengthy communications. Clients, "recipients," and "consumers" are somewhat depersonalizing, but at least not dehumanizing, and are suggested as the terminology of choice.

Approaches to Coordination

RECOMMENDATION 56

Since most people have needs that transcend the services of a ungle agency, there must be interagency coordination. In seeking coordination, the following approaches may be

A Joint funding requests in the form of state budget requests or federal grant applications. In developing the request the applicant agencies can recognize and resolve coordination problems. Alternatively, the review or funding agent can require it.

- B. The contractual purchase of services by one agency from another produces clearly defined, very workable relationships.
- C. The outstationing or co-location of staff in another agency produces better cooperation through accessibility and understanding of each other's services and limitations, if the administration of the host agency insists on this cooperation (e.g. housing mental health staff in social services offices can make needed mental health services more available to public welfare recipients). The types of agency staff to be co-located will vary with the characteristics and service needs of the community or neighborhood in which the host agency is located.
- D. Information and liaison is not truly a coordination mechanism. However, sharing of information in an area of common concern can eliminate the need for more formal arrangements and can enable joint planning.
- E. Steering committees usually provide direction for a discrete project or activity. They may serve as focal points for inputs concerning the project and can have real control over the project.
- F. Advisory committees frequently operate in broad areas of concern and may include representatives from various levels of government, professional disciplines, special interest groups, consumers, and the general public.
- G. Task forces are usually interagency groups created for the specific purpose of initiating needed services or diagnosing and correcting problems with existing services.
- H. Interagency agreements may serve a coordinating function by themselves or may simply document the conditions of some other coordinating function.

EXPLANATION

Committee research disclosed numerous approaches to services coordination. None represent the one best way of coordinating services under all circumstances and for all time. Mental health system agencies should be aware of and practice a range of approaches to coordination.

Administrative Supports for Coordination

RECOMMENDATION 57

Successful client level services coordination requires administrative supports, including the following.

- A. The area of coordination (a specific client or a specific activity) needs to be clearly defined.
- B. Delivery level staff should be involved in all levels of the planning and coordination process.
- C. Good communication in an agency is vital; information must move as readily from the service delivery to the administrative level as it does from the administrative to the service delivery level.
- D. The basic service needs of the consumer and means of meeting them must be identified, based on both state and local input, and mutually agreed upon by the agencies involved.

- E. The agency and the staff which are responsible for services coordination must also have the authority for implementation.
- F. It must be recognized that effecting coordination at the service delivery level requires time and effort. Appropriate allowances must be made in the agency staffing, coordinator's work load, etc.
- G. An ongoing program of training and education must be in place to further greater cooperation by local agency boards and better understanding and acceptance of local mental health programming by the general public.
- H. A mechanism for service delivery must be developed for the client for whom few or no services exist in a given area.
- I. Human services councils composed of all agencies providing human services within a given geographic area are useful in developing and monitoring interagency agreements for services coordination.

EXPLANATION

Wishing won't make coordination so. Its preconditions and supports must be in place throughout Michigan's public mental health system. This recommendation describes some of those critical supports.

Human Services Councils

RECOMMENDATION 58

A human services council should be created at the local level to be the focus for coordinating the activities of all human services agencies in the council's geographic area. To this end, enabling legislation is recommended which will provide that:

- A. Each county shall have the option of creating a human services council:
- B. Counties should have the option of joining together to create a human services council;
- C. Human services councils shall include: representatives from the affected county board(s) of commissioners, one representative from each participating public and private human services organization, and consumers and/or their representatives.
- D. Each participating human services organization must annually sign a memorandum of agreement indicating a willingness and desire to cooperate with other human services organizations and to actively participate on the council for one year; and
- E. Human services councils may form committees to better address specific populations or specific needs.

EXPLANATION

"Turfism" is frequently a barrier to coordinating and eliminating duplication in services delivery. A neutral body in which all involved parties participate equally is useful in allaying this problem. The basic features of such human services councils, used on a pilot basis in Michigan and more widely in Minnesota and other states, are described in the recommendation.

Local Level Interagency Agreements and Contracts

RECOMMENDATION 59

These terms are defined.

- A. Interagency agreement: An agreement between two or more agencies which clarifies responsibilities and relationships, toward the improved coordination, continuation, and expansion of services to mentally ill, emotionally disturbed, and developmentally disabled persons.
- B. Contract: An agreement which documents a purchase of services arrangement between two or more agencies, organizations, or individuals for the provision of services to mentally ill, emotionally disturbed, and developmentally disabled persons.

RECOMMENDATION 60

Interagency agreements of the local mental health authority or agencies serving clients of the local mental health authority shall address process standards in the following way.

- A. Interagency agreements will be established as a result of the need for coordination or clarification of responsibilities identified by two agencies or by the human services council.
- B. Interagency agreements will be reviewed for comment by the human services council and where such an organization does not exist, by an appropriate committee of the county board of commissioners.
- C. Interagency agreements shall also be reviewed by the Department of Mental Health Regional Office for comment and consideration of any relationship to or conflict with existing state level agreements. These agreements will also be reviewed for appropriateness in terms of the rules and policies of the Department.

RECOMMENDATION 61

Local level interagency agreements shall address policy standards including guidelines for coordination, reporting, and communication to occur between the cooperating agencies through inclusion of the following content.

- A. These general provisions will be clearly stated:
 - 1. The nature of the agreement including identification of the agencies or parties involved:
 - 2. The purposes and goals of the agreement:
 - 3. The target population being served:
 - 4. The reasons for entering into the agreement;
 - The functions and responsibilities to be performed: and
- 6. The definitions of key terms being used in the agreement.
- B. The administrative relationships among the participating agencies will be stated including:
 - The responsibilities and authorities of the liaison personnel;
 - 2. The plans for joint staff development, including:
 - a. Interdisciplinary team training for liaison personnel, and
 - b. Training and conference sessions for affected agency personnel;
 - 3. The provisions for continuing review and evaluation of the program including a schedule for doing so:

- 4. The joint development of operating procedures: and
- 5. The specific programs of the cooperating agencies which are to be used.
- C. The terms of service delivery will be specified including:
 - The services provided by each agency and any conditions attached to their availability including:
 - a. The methods by which services will be provided,
 - b. Who will provide the services, and
 - c. When they will begin; and
 - 2. The referral and follow-up procedures to be established, where appropriate.
- D. The means of financing the agreement's implementation will be addressed and will cover, where appropriate:
 - 1. The fiscal responsibilities of each agency for
 - a. Fee arrangements,
 - b. Staffing,
 - c. Provision of space,
 - d. Secretarial help,
 - e. Public information,
 - f. Inservice training,
 - g. Office equipment, and
 - h. Transportation;
 - The responsibilities for overseeing the budget accompanying the agreement, if applicable;
 - 3. The source or sources of funding; and
 - 4. The mechanisms for joint funding proposals following the first year of the agreement.
- E. The extent to which information will be exchanged will be delineated including:
 - 1. The agreement that mutual sharing of information about services and clients served will occur;
 - 2. The kinds of information needed by each agency;
 - The responsibility of each agency for furnishing information: and
 - 4. The responsibility for maintaining appropriate confidentiality of information shared by others.
- F. The functions of the personnel who carry out the agreement will be specified including:
 - 1. Their numbers and qualifications:
 - 2. Their job descriptions; and
 - The control and supervision of any jointly funded personnel.
- G. The period of time covered by the agreement will be identified including:
 - 1. Its effective date:
 - 2. The length of time the agreement will run: and
 - 3. The conditions for renewal, modification or early termination.
- H. Notification and dissemination procedures will be specified including:
 - Distribution of the agreement to affected personnel of the cooperating agencies;
 - Dissemination of changes and terminations to agencies affected by the agreement; and
 - 3 The use of media to inform the public of the agreement's implementation, revision or termination.

RECOMMENDATION 62

The local mental health authority will, with participant securies and an outside source, monitor local level agree-

ments related to the local mental health authority at the following intervals:

- A. The first formal review will occur six months after the agreement is signed;
- B. The second review will be conducted one year after the agreement is signed; and
 - C. Subsequent reviews shall be annual.

RECOMMENDATION 63

Contracts between the local mental health authority and local agencies shall follow the same basic guidelines and policies as for interagency agreements. Specific guidelines and policy affecting contracts are as follows.

- A. A contract with the local mental health authority is entered into under the authority granted by Public Act 258 of the Public Acts of 1974, as amended, and in accordance with the rules and regulations of the Michigan Department of Mental Health.
- B. The contract is specifically between the local mental health authority and an agency or individual being requested to provide services for the local mental health authority. Therefore, final authority regarding contracts rests with the local mental health authority.
- C. The Michigan Department of Mental Health has responsibility for developing specific guidelines and outlines for contractual agreements made by the local mental health authority.
- D. The human services council shall encourage the local mental health authority to utilize existing resources and agencies to provide services to the clients of the authority before developing new services which will be duplicative.

EXPLANATION

The interagency agreement is an increasingly used mechanism for coordinating the activities of agencies and service delivery systems. However, inconsistencies and omissions in those agreements contribute to problems in their successful implementation.

The Committee's Systems Relationships Subcommittee has thoroughly reviewed all existing interagency agreements and several contracts of the Michigan Department of Mental Health. It has examined several local agreements and contracts and reviewed several national studies of cooperative service agreements. The process for developing, implementing, and reviewing agreements in Michigan has also been studied. The recommendations describe features in the content, development, and use of interagency agreements that would, if regularized, contribute to the effectiveness of interagency agreements in coordinating service delivery.

The Governor's Human Services Cabinet

RECOMMENDATION 64

The Governor's Human Services Cabinet shall be revitalized to promote state interagency cooperation.

EXPLANATION

State level policy and procedural barriers exist to coordinated service delivery. The use of one mechanism for overcoming these barriers, interagency agreements, has been

often flawed by the failure to adequately review and monitor their development and operation. The Governor's Human Services Cabinet could compel resolution of state level coordination issues. Annual rotation of the Cabinet chair responsibility among department directors is proposed as a means of making the Cabinet more viable. Services coordination by the Human Services Cabinet provides a state level parallel to local human services councils.

-State Level Interagency Agreements RECOMMENDATION 65

State level interagency agreements of the Michigan Department of Mental Health shall address policy and process standards including guidelines for coordination, reporting, and communication that will occur among the cooperating agencies through inclusion of the following content.

- A. These general provisons will be clearly stated:
 - 1. The nature of the agreement including identification of the agencies or parties involved;
 - 2. The purpose and goals of the agreement:
 - 3. The target population being served:
 - 4. The reason(s) for entering into the agreement;
 - The functions and responsibilities to be performed; and
 - The definitions of key terms being used in the agreement.
- B. The administrative relationships among the participating agencies will be stated, including:
 - The responsibilities and authorities of the liaison personnel, and
 - 2. The plans for joint staff development including:
 - a. Interdisciplinary team training for liaison personnel, and
 - b. Training and conference sessions for affected agency personnel;
 - 3. The provisions for continuing review and evaluation of programs including the schedule for doing so;
 - 4. The joint development of operating procedures; and
 - 5. The specific programs of the cooperating agencies which are to be used.
- C. The terms of service delivery will be specified including:
 - 1. The services provided by each agency and any conditions attached to their availability;
 - a. The method by which the services will be provided.
 - b. Who will provide the services, and
 - c. When they will begin; and
 - 2. The referral and follow-up procedures to be established, where appropriate.
- D. The means of financing the agreement's implementation will be addressed and will cover, where appropriate:
 - 1. The fiscal responsibilities for each agency for
 - a. Fee arrangements,
 - b. Staffing,
 - c. Provision of space,
 - d. Secretarial help,
 - e. Public information,
 - f. Inservice training,

- g. Office equipment, and
- h. Transportation:
- 2. The responsibilities for overseeing the budget accompanying the agreement, if applicable:
- 3. The source(s) of funding: and
- 4. The mechanisms for joint funding proposals following the first year of the agreement.
- E. The extent to which information will be exchanged will be delineated, including:
 - The agreement that mutual sharing of information about services and clients served will occur:
 - 2. The kinds of information needed by each agency:
 - 3. The responsibility of each agency for furnishing information; and
 - 4. The responsibility for maintaining appropriate confidentiality of information shared by others.
- F. The functions of personnel who carry out the agreement shall be specified including:
 - 1. Their numbers and qualifications:
 - 2. Their job descriptions: and
 - 3. The control and supervision of any jointly funded personnel.
- G. The period of time covered by the agreement will be identified including:
 - 1. Its effective date;
 - 2. The length of time that the agreement will run: and
 - 3. The conditions for renewal, modification, or early termination.
- H. Notification and dissemination procedures will be specified including:
 - 1. Distribution of the agreement to affected personnel of the cooperating agencies;
 - Dissemination of changes and termination to agencies affected by the agreement; and
 - 3. The use of media to inform the public of the agreement's implementation, revision, or termination.

RECOMMENDATION 66

The process used by the Michigan Department of Mental Health in developing state level interagency agreements shall include:

- A. Use of a standardized format;
- B. Review and approval of the Governor's Human Services Cabinet prior to final signature, subject to the following conditions.
 - 1. When the agreement is required by federal law, the Human Services Cabinet will neither apply standards which conflict with those set by the federal government, nor unnecessarily delay negotiation and implementation of the agreement; and
 - The Human Services Cabinet shall not approve the right of any state department to make an agreement. but rather the conditions surrounding the agreement. such as:
 - a. Does it needlessly duplicate already existing
 - b. Will it reasonably produce the desired outcome:
 - c. Is the program adequately funded;
 - d. Are the proposed methods of implementation fully feasible; and
 - e. Does the document comply with these guidelines; and

C. Involvement of the Department of Management and Budget to synchronize the agreement's implementation with its supporting resources and the state budget cycle.

RECOMMENDATION 67

The Governor's Human Services Cabinet will, with participant agencies, field personnel, and an outside source, monitor state level agreements of the Michigan Department of Mental Health at these intervals:

- A. The first formal review will occur six months after the agreement is signed;
- B. The second review will be conducted one year after the agreement is signed; and
 - C. Subsequent reviews shall be annual.

At three years, consideration should be given to either giving the agreement a stronger authority base, revising it, or terminating it.

RECOMMENDATION 68

All state level agencies wishing to enter into agreements with the Michigan Department of Mental Health shall be required to follow these guidelines for state level interagency agreements in the development of those agreements.

RECOMMENDATION 69

If after an appropriate period of time the effectiveness and value of these guidelines shall be established, it will be desirable that this mandate be extended to all state level interagency agreements.

EXPLANATION

These recommendations have the same basis as do the recommendations for local level agreements. State level agreements were found to be particularly deficient in provisions that would assure implementation at the client level and monitoring of the agreements' continued functioning.

Legislative Liaison

RECOMMENDATION 70

A formal mechanism shall be established to involve local mental health authorities in proposing legislative change and giving feedback on the impact of new legislation.

EXPLANATION

The Committee is recommending that legislative liaison be a joint function of the Department of Mental Health and like all mental health authorities. The function involves communicating with staff and members of the Michigan Legislature and the United States Congress on issues of appropriations for mental health programs and changes in and creation of enabling statutes.

This recommendation further explains how that function should be carried out. It does not intend to curtail the legis-activation that now normally and accurs, but to create an orderly upward and downward process for knowledge of and input to the legislative princess for mental health programs.

In adopting this recommendation the Committee considered and rejected an alternative which would have continued the present practice of having the Department of mental health and the Governor maintain their present singular responsibility for proposing and promoting legislation that is beneficial to mental health programs.



RECOMMENDATION 71

Increased emphasis and sufficient funding shall be given to continuing relevant public mental health research activities. All legitimate manners and sources of funding outside of Michigan's public mental health system shall be pursued to support research activities.

RECOMMENDATION 72

The Department of Mental Health, in cooperation with local mental health authorities, shall regularly set priorities for research topics which are relevant to public mental health system clients.

RECOMMENDATION 73

Michigan's public mental health system will promote the dissemination of research results and the application and implementation of practices proven through research to be successful.

RECOMMENDATION 74

Increased interaction shall be fostered between Michigan's public mental health system and the scientific/ academic community to facilitate cooperation on research areas relevant to mental health service delivery systems.

RECOMMENDATION 75

Primary prevention research, innovation, and dissemination shall be a mandated function of the State Department of Mental Health.

EXPLANATION

The Committee considers research to be a mental health system priority that is essential to improving the quality of the system's services. These recommendations provide additional detail for the research and the dissemination of innovation functions assigned to the Department of Mental Health and for the research activities in which local mental health authorities may engage.



State and Local Shares

RECOMMENDATION 76

State and local funding will be provided for both mandatory and supplemental mental health programs at the 90-10 ratio.

EXPLANATION

Since enactment of the 1974 Mental Health Code, state and county governments have been required to share the cost of both state and community programs on a 90-10 basis. The Committee recommends continuing this practice. Such sharing will affirm the responsibility of local government for not only providing services but also for making a financial commitment to them.

The following alternatives were considered but not recommended:

- 1. Both mandatory and supplemental programs will be totally state funded.
- 2. Mandatory programs shall be totally state financed and supplemental programs will be totally locally financed.
- 3. Mandatory programs will be state funded and supplemental programs will be both state and locally funded.
- 4. Lix al funding will be provided for both mandatory and supplemental programs and state funding will be provided tor only mandatory programs.

Local Funds

RECOMMENDATION 77

The continued local funding of mental health programs shall be supported by:

- A. Requiring current dollar maintenance of effort funding, at the 10% level specified in the FY '79-'80 allocation;
- B. Increasing the available local funds by broadening the definition of local match to include
 - 1. Client fees, including third party payments,
 - 2. Non-governmental grants,
 - County funds allocated to probate courts for mental health costs.
 - 4. Donated in-kind commodities and services,
 - 5. Expenditures of other county departments on mental health clients, and
 - All legal obligations, insurance costs, judgments, and settlements arising from the operation of the local program;
- C Earmarking "Headlee Dividend" dollars for local mental health services: and
- D. Allowing state funds paid as a "Headlee Dividend" to be used as local matching funds.

EXPLANATION

The Director of the Department of Mental Health has erred the Committee to make recommendations that provide

stable and ample funding for public mental health services. The portion of total community program costs that is now actually paid by local governments ranges from 2 to 32 percent. Whatever the current level of local financial commitment, many community programs are unable to get new local funds for program expansion.

Increased difficulties in securing local funding for mental health services are expected as the impact grows of the Headlee Amendment to the Michigan Constitution. The Amendment's millage rollback provision will effectively reduce the services which local governments can support. Simultaneously, its provision fixing the share of the state budget that must be directed to local governments will, for the next decade, due to declining K-12 school enrollments, make more state funds available to local governments.

The Committee recommends supports for the continued and greater availability of local funds for mental health programs. The definition of what can be counted for the ten percent local share is broadened in a recommendation that is largely consistent with the proposals of the Mental Health Committee of the Michigan Association of Counties, the Michigan Association of Community Mental Health Boards, and the Michigan Association of Community Mental Health Directors.

It is additionally recommended that a portion of the state funds which the Headlee Amendment requires be paid to local governments be designated by the Legislature for mental health programs. These funds would also then be considered as part of the ten percent local share.

Allocating State Funds

RECOMMENDATION 78

State funds will be allocated to local mental health authorities on a per capita basis, as weighted by a measure of the economic resources of the service area and the numbers of persons in the area that are in need of mental health services.

EXPLANATION

While there is little agreement on how equity should be measured, it is widely believed that the current distribution of state funds to local mental health programs is inequitable. If per capita allocations are the measure for equity, the range for the 1977-78 fiscal year was from \$3.53 to \$19.34.

The Committee recommends a basic per capita distribution of state funds. This distribution should be weighted by a measure of the economic resources that impact on the community's ability to support mental health services. Additional weighting by demonstrated need for mental health services supports the Mental Health Code's requirement that services be given first to persons in greatest need.

Increased Funding

RECOMMENDATION 79

The funds appropriated to public mental health programs should be sufficient to make adequate and appropriate services available to all persons who need them.

RECOMMENDATION 80

Improved coordination is not a panacea. Effective use of existing resources is prerequisite. However, in certain circumstances adequate, realigned, or increased funds will be required to address human need.

EXPLANATION

The Committee was convened to address the problems and inequities in Michigan's state and community mental health care systems. The changes in policy and practice proposed in the Committee's recommendations will remedy many of the deficiencies. Others will be remedied, quite simply, only when more resources are provided for mental health and other human services.

"Into the Eighties" is respectfully submitted to Governor William G. Milliken by:

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(Signatories)

Part V

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Part VI

Minority Reports

Samuel L. Davis and Mildred A. Ellis

The Final Report would have been a richer, more human document if it had addressed the specialized needs of different population groups served by the mental health system. Recommendations made without distinguishing between age groupings often ignore variations in planning, budgeting, and service delivery that are essential if such problems as waiting lists, gaps in service, fragmentation, and unevenness in quality are to be solved.

Mental health practitioners are confronted daily with unique problems in providing care and treatment to children and adolescents, yet the Final Report neither identifies these problems nor the specialized approaches that are available to solve them. This is particularly distressing to those in the children's field as testimony at public hearings and other communications received by the Governor's Committee indicates.

We believe that there are many specific recommendations that could have been made to improve services to children and adolescents. First, and most important:

Child and adolescent services must be accepted as a specialized area and it must be understood that planning requirements and direct service methods often differ from those that are appropriate for adult and mental retardation services.

In addition, we would like to offer the following recommendations:

- 1. The Department of Mental Health should establish a Central Office position of Director of Child and Adolescent Services. This position should be filled by a person with clinical and planning experience in children's services: should be properly compensated; and should be at an organizational level that ensures influence in Department decision-making.
- 2. The Governor should direct the various departments of State government to coordinate efforts on behalf of disturbed children and adolescents. Meaningful coordination is desperately needed between schools and mental health agencies; and mental health agencies, the courts, residential care programs, and the Department of Social Services.
- 3. The recruitment and retention of trained professional workers must be given priority. Implicit in this recommendation is the belief that trained mental health workers must be permitted to participate in the development of policies that effect clinical practice: and that Department of Mental Health leadership must emphasize the importance of specialized training in working with children.
- 4. Training instutitions (universities and agency in-service training programs) must emphasize the value of knowledge in child development and psychopathology and provide well-supervised clinical experiences for students and workers.
- 5. The Department of Mental Health must reassess its evaluation, accountability, and reporting requirements be-

cause these are often viewed by practitioners as both limited in value and wasteful in time and energy.

- 6. Community mental health boards and the Department of Mental Health should set as their goal the development of a true network of services for children and adolescents: all program elements of this network must be in place for any one to work effectively.
- 7. Improved financial support for child and adolescent services is still needed, especially in such areas as prevention and residential care services.*

It is our hope that the Governor, the Legislature, and the Director of the Department of Mental Health will recognize that emotionally disturbed children and adolescents, and other population groups as well, require services which are tailored to their distinctive needs.

*The above recommendations are the product of the Working Conference on Child and Adolescent Treatment Services for the Emotionally Disturbed sponsored by the Michigan Association for Emotionally Disturbed Children, the University of Michigan School of Social Wrok and the Washtenaw County Community Mental Health Center in 1978.

Henry P. Widrich

As per decision of the Governor's Committee on Unification of the Public Mental Health System, I submit herewith a few thoughts which may be considered a minority report of one.

1. Members of any mental health board must not be appointed by a board of commissioners, which constitutes a political appointment. According to the preceding final report to the Governor, the local community mental health board will be regarded as the single point of entry. Therefore, it becomes of paramount importance that the body which will serve the client best must consist of people who will have the necessary expertise to make the needed decisions.

Recommendation

The community must appoint an advisory board to the board of commissioners consisting of people who have the required expertise to deal with the problems of mentally ill and developmentally disabled clients. Such an advisory board must also include consumer representation. This advisory board, in turn, will appoint qualified members to the community mental health board which does not preclude that members of the advisory board of part thereof can, in fact, constitute the community mental health board.

- 2. State facilities must remain autonomous and be subjected to control by the Central Office. If the Department of Mental Health will be unified, there is no room for exceptions. Furthermore, community mental health boards, wherever geographically possible, should be required to avail themselves of these facilities for the procedure of single entry and exit in and out of the system.
- 3. It has been suggested in this report that a second opinion may be obtained by the client's parent/guardian if it applies to surgery only. This statement is too narrow. It excludes certain aspects of medical treatment which could require a second opinion.

Recommendation

Include eye, ear, and dental treatments.

4. A recommendation was presented to the Committee stating that within the Department, a separation should be made between services to mentally ill and developmentally disabled individuals. The Committee voted to let the Director of the Department make this decision. Reference is also made in this report to the States of New York and California which, from a dual system, changed to a single system for mentally ill and developmentally disabled individuals. To the best of my knowledge, the State of California changed back to the dual system.

In an informal survey taken last October at Oakdale with the presence of over 100 people (parents, relatives, guardians) an overwhelming majority felt that the needs of all clients would be much better served if such a separation were to be made. The Department of Mental Health is urged to reconsider its position. The same concerns were also voiced at the public hearings. 5. It is unfortunate that the Committee, due to lack of time, did not consider the needs of individuals who are both mentally ill and developmentally disabled. It is suggested that the Department and Legislators, by providing the needed funds, address themselves to this problem by developing special programs and residences for these individuals.